ELECTRONIC BENEFITS PAYMENT DEDUCTION AUTHORIZATION FORM

I authorize the State of Montana Health Care & Benefits Division, and the financial institution listed below, to electronically **deduct benefits payment** for the State Employee Group Benefits Plan on a monthly basis from my (check one):

☐ Checking Account ☐ Savings Account

Month in which to start deduction: _____

This form is (check one):

☐ For initial setup for benefits payments ☐ To make a change to an existing benefit payment

- This authorization will remain in effect until I cancel in writing.
- I understand the benefits payments deducted from my account will change automatically if the group rates change, or if any changes are made to my coverage with the State Employee Group Benefits Plan.

_____ _____

Signature Date

A voided check or savings deposit slip must be attached here for the authorized account

PLEASE COMPLETE THE FOLLOWING:

_____ XXX- XX-_____

Print full name Last 4 of Social Security Number

Return completed form to:
Health Care and Benefits Division PO Box 200130 Helena, MT 59620-0130